

**BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS**  
**IN MEDICINE AND SURGERY**

IN THE MATTER OF:	)	<b>Case No.: DO-15-0289A</b>
	)	
<b>MICHAEL SHELL, D.O.</b>	)	
Holder of License No. <b>2921</b>	)	<b>CONSENT AGREEMENT AND ORDER</b>
	)	<b>FOR PROBATION</b>
For the practice of osteopathic medicine in the	)	
State of Arizona	)	
	)	
	)	

## CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Board of Osteopathic Examiners in Medicine and Surgery (“Board”) and Michael Shell, D.O. (“Respondent”), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order (“Consent Agreement”). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. Respondent admits to the findings of fact and conclusions of law contained in the Consent Agreement and Order.

1           5.     This Consent Agreement, or any part thereof, may be considered in any future  
2 disciplinary action against Respondent.

3           6.     Upon signing this agreement, and returning this document (or a copy thereof) to  
4 the Board's Executive Director, Respondent may not revoke the acceptance of the Consent  
5 Agreement. Respondent may not make any modifications to the document. Any modifications  
6 to this original document are ineffective and void unless mutually approved by the parties.

7           7.     This Consent Agreement, once approved and signed, is a public record that will  
8 be publicly disseminated as a formal action of the Board and will be reported to the National  
9 Practitioner Data Bank and to the Board's website.

10          8.     If any part of the Consent Agreement is later declared void or otherwise  
11 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and  
12 effect.

13          9.     If the Board does not adopt this Consent Agreement, (1) Respondent will not  
14 assert as a defense that the Board's consideration of the Consent Agreement constitutes bias,  
15 prejudice, prejudgment or other similar defense; and (2) the Board will not consider content of  
16 this Consent Agreement as an admission by Respondent.

17                   REVIEWED AND ACCEPTED THIS 10 DAY OF December 2016.

18  
19                   Michael Shell, D.O.  
20 Michael Shell, D.O.

21  
22                   **JURISDICTIONAL STATEMENT**

23           1.     The Board is empowered, pursuant to A.R.S. § 32-1800, *et seq.* to regulate the  
24 licensing and practice of osteopathic medicine in the State of Arizona.

25           2.     Respondent holds license No. 2921 issued by the Board to practice as an  
26 osteopathic physician.  
27

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7

2  
3

4

5  
6  
7  
8

9  
0  
1  
2

3  
4  
5

6  
7  
8  
9  
20  
21

22  
23  
24  
25

1 f. Respondent's pain management medical care and the documentation of his  
2 medical care of B.B. were at times substandard.

3 g. On or about April 27, 2011 through December 27, 2012, Respondent provided  
4 medical care in the form of pain management for patient J.G. At different times and in  
5 different combinations, Respondent treated J.G.'s pain, anxiety and panic attacks with  
6 medications including, MS Contin, hydrocodone/acetaminophen, Ativan, carisoprodol,  
7 Roxicodone, Xanax, Neurontin BuSpar and Zanaflex.

8 h. During the course of treatment provided by Respondent for J.G., Respondent  
9 failed to adequately document his review of earlier physician pain management records  
10 for J.G. to ascertain prior treatments and responses with either interventions or  
11 medications, as well as possible signs of aberrant behavior.

12 i. During the course of treatment provided by Respondent for J.G., Respondent  
13 failed to adequately refer to the Physician Drug Monitoring Program ("PDMP") despite  
14 the use of chronic opioid therapy with the addition of other potentially addicting  
15 medications such as Ativan or soma. It appears that J.G. was obtaining prescriptions  
16 from other providers, which is not referenced by Respondent in his records.

17 j. During the course of treatment provided by Respondent for J.G., J.G. had several  
18 "red flags" associated with chronic opioid care, such as a result of a stolen prescription,  
19 that J.G.'s wife had used his medication, and requests for early refills, all of which can be  
20 suggestive of diversion and/or abuse.

21 k. On or about December 28, 2012, J.G. died as a result of an accidental overdose.

22 l. Respondent's pain management medical care and the documentation of his  
23 medical care of J.G. were at times substandard.

24 m. On or about July 29, 2008 through January 10, 2014, Respondent provided  
25 medical care in the form of pain management for patient D.O. During these years of  
26 treatment, Respondent treated D.O. at different times with opioids, including those  
27

1 containing hydrocodone, fentanyl, Morphine, Dilaudid, and oxycodone. In addition,  
2 Respondent treated D.O.'s pain and anxiety with, methylprednisolone and Ambien.

3 n. During the course of treatment provided by Respondent for D.O., the medical  
4 records do not reflect Respondent's typical practice of obtaining an initial informed  
5 consent for chronic pain management and an opioid contract for new patients.

6 o. During the course of treatment provided by Respondent for D.O., Respondent did  
7 not recognize D.O.'s deceptive behavior in obtaining prescription medications from  
8 multiple providers by referring to the PDMP until March 2013.

9 p. During the course of treatment provided by Respondent for D.O., D.O. had  
10 several "red flags" associated with chronic opioid misuse, such as a report of stolen  
11 medications and reference in the PDMP which indicated that D.O. was being provided  
12 medications from three (3) different providers, which are suggestive of diversion and/or  
13 abuse.

14 q. Respondent's pain management medical care and the documentation of his  
15 medical care of D.O. were at times substandard.

16 r. On or about July 31, 2007 through January 15, 2014, Respondent provided  
17 medical care in the form of pain management for patient T.N. At different times,  
18 Respondent treated T.N.'s chronic pain with opioids containing morphine, hydrocodone  
19 and oxycodone.

20 s. During the course of treatment provided by Respondent for T.N. objective testing  
21 showed only degenerative changes with no ongoing pathology consistent with T.N.'s  
22 subjective complaints of low back pain.

23 t. During the course of treatment provided by Respondent for T.N., T.N. had several  
24 "red flags" associated with chronic opioid misuse, requests for and actually obtaining  
25 early refills and a notation that T.N. has presented the same prescriptions to multiple  
26 pharmacies on the same day, which are suggestive of diversion and/or abuse.

1 u. Respondent's pain management medical care and the documentation of his  
2 medical care of T.N. were at times substandard.

3  
4 **CONCLUSIONS OF LAW**

5 1. Pursuant to A.R.S. § 32-1800, *et seq.* the Board has subject matter and personal  
6 jurisdiction in this matter.

7 2. The conduct and circumstances as described in the paragraphs above, constitute  
8 unprofessional conduct as defined in the following paragraphs of A.R.S. § 32-1854:

9 (6) Engaging in the practice of medicine in a manner that harms or may harm  
10 a patient or that the Board determines falls below the community standard.

11 (18) The denial of or disciplinary action against a license by any other state,  
12 territory, district or country, unless it can be shown that this occurred for reasons  
13 that did not relate to the person's ability to safely and skillfully practice  
osteopathic medicine or to any act of unprofessional conduct as provided in this  
section.

14 (38) Any conduct or practice that endangers a patient's or the public's health or  
15 may reasonably be expected to do so.

16  
17 **ORDER**

18 Pursuant to the authority vested in the Board, **IT IS HEREBY ORDERED** that Michael  
19 Shell, D.O, holder of osteopathic medical License number 2921, voluntarily agrees to the  
20 following:

21 1. Respondent shall comply with any and all terms of the Stipulation and Final  
22 Agency Order issued by the Colorado Medical Board on December 4, 2015.

23 2. Respondent shall not apply for or obtain a DEA registration in Arizona without  
24 receiving prior approval by the Board.  
25  
26  
27

3. Respondent's Arizona license, no. 2921 is placed on PROBATION for a minimum period of three (3) years. Respondent shall petition the Board for termination of this Consent Agreement and Order.

4. Any modifications to Stipulation and Final Agency Order issued by the Colorado Medical Board on December 4, 2015, shall have no effect on this Consent Agreement and Order for Probation. In addition, Respondent must seek termination of this Consent Agreement and Order from the Board.

4. Any costs of compliance with this Order are to be borne by Respondent.

5. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in the State of Arizona.

6. Respondent shall appear in person before the Board or Board staff for interviews upon request, upon reasonable notice.

7. Respondent shall notify the Board within ten (10) days, in writing, of any change in office or home addresses and telephone numbers.

8. Respondent's failure to comply with the requirements of this Order shall constitute an allegation of unprofessional conduct as defined at A.R.S. § 32-1854(25); proven violations may be grounds for further disciplinary action (e.g., suspension or revocation of license).

9. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effective.

ISSUED THIS 14<sup>th</sup> DAY OF December, 2016.  
STATE OF ARIZONA  
BOARD OF OSTEOPATHIC EXAMINERS  
IN MEDICINE AND SURGERY

By: Jenna Jones  
Jenna Jones, Executive Director

1  
2  
3 Original filed this 14<sup>th</sup> day of December, 2016 with the:

4 Arizona Board of Osteopathic Examiners  
5 In Medicine and Surgery  
6 9535 East Doubletree Ranch Road  
7 Scottsdale AZ 85258-5539

8 Copy of the foregoing sent via certified mail, return receipt requested this  
9 14<sup>th</sup> day of December, 2016 to:

10 Scott King, Esq.  
11 Broening Oberg Woods & Wilson  
12 Address of record

13 Copy of the foregoing sent via regular mail  
14 this 14<sup>th</sup> day of December, 2016 to:

15 Michael Shell, D.O.  
16 Address of Record

17 And

18 Jeanne Galvin, AAG  
19 Office of the Attorney General SGD/LES  
20 1275 West Washington  
21 Phoenix AZ 85007  
22  
23  
24  
25  
26  
27